U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

DATE: March 2, 2000
CASE NO. 1999-LHC-1183
OWCP NO. 03-26930

In the Matter of

MARK ALVIN MITCHELL
Claimant

v.

CENTOFANTI MARINE SERVICES, INC.
Employer

and

LEGION INSURANCE COMPANY
Carrier

Appearances:

Joseph P. Moschetta, Esquire
For the Claimant

Andrew Klaber, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER - AWARDING BENEFITS

This case arises from a claim for compensation under the Longshore and Habor Workers' Compensation Act, as amended, 33 U.S.C. §901, et seq. ("LHWCA" or "the Act"). A hearing was held on before me on September 24, 1999, in Pittsburgh, Pennsylvania, at which time all parties were given a full and fair opportunity to present evidence and argument. Claimant's exhibits (CX) 1-27 and 31-33, Employer's exhibits (EX) 1-27 and Administrative Law Judge (ALJX) exhibit 1 were admitted into the record without objection. Employer's objection to

admitting CX 28-30 and 34 was overruled and admitted into evidence. The record remained open for post-hearing evidence admission and the submission of closing briefs. Employer's Exhibits 28 and 29 and closing briefs for both parties were admitted post-hearing.

I. STIPULATIONS (ALJX 1)

The parties stipulate and I therefore find:

A. The Claimant sustained an accidental injury on or about April 7, 1998, while working for the Employer, under the circumstances bringing the injury within the Act.

B. The Claimant was employed by the Employer as a Welder at the time of the work-related injury of April 7, 1998.

C. The Employer filed an Employer's First Report of Injury or Occupational Illness on April 9, 1998.

D. The Claimant reported the accident to the Employer on April 7, 1998.

E. The Claimant has not worked since his injury.

F. The Claimant received temporary total disability payments in the amount of $208.94 per week for thirty (30) weeks, commencing on April 8, 1998, and extending through November 3, 1998, for a total of $6,268.20.

G. The Employer terminated all weekly disability benefit payments and medical payments pursuant to a Notice of Final Payment or suspension of Compensation Payments issued to the Claimant on November 4, 1998, because "medical records do not relate disability to work injury."

H. The Claimant's Average Weekly Wage ("AWW") is $247.10.

I. The Claimant's Compensation Rate (AWW x 2/3) is $208.94.

II. ISSUES

The issues to be resolved are:

A. Whether Claimant is totally disabled as a result of work-related injuries which occurred on April 7, 1998.

B. Whether Employer should pay Claimant's medical expenses incurred since

November 3, 1998, and whether Employer should provide such additional services as Claimant's condition may require.

III. FINDINGS OF FACT

A. Background and Testimonial Evidence

Mark Mitchell (hereinafter Claimant) is 38 years old. He obtained his GED while serving in the U.S. Army. Claimant began working for Employer on March 9, 1998, as a welder trainee. (Tr. 133, 134; EX 16). On April 7, 1998, Claimant, while working on Employer's barge, sustained a head injury when a chain binder snapped and hit him on the head. (ALJX 1). At the hearing held on September 24, 1999, in Pittsburgh, Pennsylvania, Claimant, his wife Katrina (hereinafter Mrs. Mitchell) and his father Wayne Mitchell testified at the hearing.

Claimant testified that on April 7, 1998, he was inside the barge pulling it down in order to weld the hull. (Tr. 134-135). In order to pull down the barge, a coworker was using a rachet on one side of the wall, while Claimant was using a chain binder on the other side. (Tr. 135, 141). Claimant went to put on his hood, the chain broke and hit him in the head over his left eye knocking him unconscious. (Tr. 135, 137, 138). His glasses flew off and were broken. (Tr. 142). He was not sure what part of the chain binder hit him. (Tr. 136, 166). Claimant was bleeding and was taken to the first aid area in the office by his brother. (Tr. 142-143). He was treated with a spray and a band-aid, was told it was just a scratch and was sent back to work. (Tr. 142-143). Claimant admittedly refused to go to a doctor because of a policy where he could receive $150 for not missing work. (Tr. 167). He stated the bleeding was not bad when he went back to work. (Tr. 167). He returned to the barge, but felt dizzy and did not perform any work for the rest of the day. (Tr. 143). At the end of his shift he went home and was taken immediately to the hospital by his wife where he got stitches. (Tr. 144-145). The hospital wanted him to stay but Claimant felt better at home with his wife. (Tr. 145, 184). The next day he had a throbbing headache and began experiencing blackouts. (Tr. 146).

Since the accident he has seizures, blackouts and memory loss. (Tr. 146). He has been treated for his seizures and head problems. (Tr. 168). He experiences constant numbness from his left eye to the back of his head which he did not experience prior to the accident. (Tr. 139). Claimant's blackouts are not the same as those he had from drinking. (Tr. 171). Claimant did report headaches to Dr. Edge but they were not like the headaches he experiences now. (Tr. 179). He had no memory difficulties while using drugs or drinking. (Tr. 180). Claimant had difficulty recalling prior head injuries and prior head x-rays, but did recall several accidents he was involved in including a motor vehicle accident resulting in a shoulder injury, falling off of a ladder, and a motor vehicle accident involving a truck rolling over three times. (Tr. 155-161). He stated the drinking may account for his inability to remember the incidents at the hospital or the accidents. (Tr. 172). Claimant experiences anxiety and at times he gets tense and has trouble functioning. (Tr. 173).

Claimant admitted he is a recovering alcoholic and addict. (Tr. 132). He entered Greenbriar for rehabilitation treatment to avoid going to jail for a DUI. (Tr. 147). Claimant was in rehabilitation three times before Greenbriar and was only able to stay clean for four to five months after each rehabilitation. (Tr. 175). Claimant has been clean from drugs and alcohol for two years. (Tr. 181-182).

Mrs. Katrina Mitchell (hereinafter Mrs. Mitchell) testified that her husband did not have memory problems, seizures or black outs while he was drinking alcohol or using drugs. (Tr. 41). The seizures began two to three days after the April 7th accident. (Tr. 50-52). They last three to five minutes with redness of the face, thrashing of the arms and legs, eyes rolling backing into his head, profuse sweating, and loss of control over his body. (Tr. 50-52). Claimant was prescribed seizure medication approximately one week after the accident, prior to which Claimant experienced between three to ten seizures per day. (Tr. 52-53). His seizures are less severe and less frequent on medication. (Tr. 54). Her husband's current medications are Neurontin, Naproxen, Clonzepam, and Ambien. (Tr. 55-56). Mrs. Mitchell testified that her husband experiences severe headaches evidenced by profuse sweating, a red face and sitting with his head in his hands. (Tr. 57). He did not have or complain of headaches prior to the accident. (Tr. 57). She acknowledged that her husband reported significant or severe spontaneous headaches to Dr. Edge after the truck rollover incident. (Tr. 83, 87). Her husband did not experience seizures or memory loss after the truck rollover incident. (Tr. 87). Claimant has no short-term memory since the accident. (Tr. 60). Prior to the accident Claimant had no trouble with his memory. (Tr. 64).

Mr. Wayne Mitchell (hereinafter Mr. Mitchell), Claimant's father, testified that there was no history of seizures in the family. (Tr. 104). Claimant did not have memory loss prior to the accident or when drinking. (Tr. 106-107, 113). Mr. Mitchell described two experiences after the accident where Claimant had unexplained memory loss. (Tr. 105-108). Prior to the accident Claimant would check on him but now he has to check on Claimant while hunting and fishing. (Tr. 105-106). Mr. Mitchell stated that Claimant's eyes will glass over and then suddenly Claimant would ask what was said as if he didn't hear you or as if he was not paying attention. (Tr. 109). Mr. Mitchell stated that Claimant was not like this when he was drinking. (Tr. 109). He stated that afer the accident Claimant complained of headaches, had memory loss, experienced seizures, and zoned out. (Tr. 121-122). Claimant had a seizure at Mr. Mitchell's house and he was taken to the Brownsville General Hospital via ambulance. (Tr. 121-122).

A sworn statement by Charles K. Mitchell was submitted. (CX 33). Mr. Mitchell stated that he was working with Claimant on April 7, 1998, when he was struck in the head with a chain binder. He stated that Claimant was knocked to the ground, was unconscious and was bleeding profusely. Mr. Mitchell stated the Claimant regained partial consciousness and he walked him to the office where they put a band-aid on his head and sent him back to work. He stated Claimant complained of dizziness and a headache. Mr. Mitchell stated that Claimant kept losing consciousness while looking for his glasses. When their shift ended, he took Claimant to the car and punched out his time card.

B. Medical Evidence

1. Brownsville General Hospital Medical Records

Various emergency room visits at Brownsville General Hospital are in the record. (EX 1, 14). Claimant was seen on December 20, 1991, for injuries resulting from an altercation involving his head being slammed against a windshield. Skull x-rays revealed an abnormal irregular round radiolucency in the right parietal bone measuring approximately 3 cm in diameter and may represent a cystic bone lesion, probably a dermoid cyst. There was no evidence of a fracture or increased intracranial pressure or an abnormal calcification. The lumbosacral spine and cervical spine x-rays were normal. The right knee x-ray showed no evidence of injury. Claimant was seen on April 22, 1997, for a fall resulting in mild soft tissue swelling of his left elbow. Claimant was seen on April 27 and May 27, 1997, for a left rib contusion resulting from an arrest. On July 13, 1997, Claimant was seen for a motor vehicle accident injury that occurred at work on July 12th. The skull x-ray demonstrated a 3 cm lucent or lytic lesion in the left parietal bone of which the exact nature was unknown. There was no evidence of skull fracture and no intracranial calcifications. The cella turcica and clinoid process were intact. The cervical spine x-ray was essentially negative. The right wrist x-ray revealed a 6 mm cyst or pseudocyst in the lunate bone with no evidence of fracture, dislocation, or other abnormalities. The right shoulder and left rib x-rays revealed no evidence of fracture or dislocation.

An unenhanced and enhanced brain CT scan was performed on August 15, 1997. (EX 1). The impressions were 1x3 cm lesion in the diploe of the left high parietal bone, recent skull x-rays were unchanged from previous 1991 skull x-rays indicating non-progression of lesion, multiple blood vessels appear to converge into this lesion indicating most likely an enlarged venous lake rather than metastasis, multiple myeloma or neoplastic bone lesion, no evidence of adjacent meningioma, and cerebrum and cerebellum were unremarkable with no evidence of vascular malformation, hemorrhage or infarct.

Claimant was seen again in Brownsville's emergency room on April 7, 1998, the day of the accident, for a laceration to the forehead resulting from being hit with an iron pipe at work. (CX 5; EX 1, 13, 14). An emergency unenhanced brain CT scan was performed using bone and soft tissue windows. The CT scan was compared to the CT scan performed on August 15, 1997. The impressions were no hemorrhage or ischemic infract in the brain CT scan, chronic 3 cm long lesion in the left high parietal bone, and most likely represents a prominent venous lake or other benign entities.

Claimant was seen at Brownsville's emergency room on July 2, 1998, by Dr. Scott Kim upon having a seizure. (CX 11; EX 1, 13). The diagnosis was listed as seizure disorder. Dr. Kim's notes recorded seizures from the date of the work-related injury, fifteen seizures a week before Claimant began taking Neurontin and Tegretol and frequent dizziness.

2. South Hills Health System Medical Records

Claimant's treatment records at South Hills Health System from April 9 through May 8, 1998, are in the record. (CX 6; EX 5, 13). Claimant was diagnosed with a grade 4 concussion on April 7, 1998. On April 9, 1998, Claimant was diagnosed with a head laceration and a head injury with a concussion. The treatment records document Claimant's severe concussion resulting from the work injury and its complications.

3. Jefferson Hospital Medical Records

An unenhanced CT scan of the brain was performed on April 9, 1998. (CX 7; EX 5, 14). The 3rd, 4th and lateral ventricles were normal in size and configuration. There was no midline shift or subdural collection. No areas of abnormally increased or decreased density or abnormal enhancement were seen. The cortical sulci were normal in appearance. The impression was noted as normal unenhanced CT scan of the brain.

An electroencephalogram was performed on April, 15, 1998. (CX 9; EX 5, 13). During the record, no spikes or focal slowing were seen. Good sleep was not obtained. Photic and hyperventilation produced normal responses. The impression was normal awake and drowsy.

4. Medical Reports of John Talbot, M.D.

Dr. John Talbot of Associates in Neurology of Pittsburgh submitted a medical report dated April 14, 1998. (CX 8; EX 4, 13). Dr. Talbot noted headaches that were maximum at site of impact but basically global, dizziness with intermixed true vertigo, nodding off for thirty seconds then rapidly coming around, repetition, and difficulty retaining new information. Dr. Talbot stated that he did not note any mental impairment and that a detailed neurological examination, including sensory, motor, cerebellar, and reflex examinations, did not reveal any abnormalities. He reviewed the April 9, 1998, CT scan and found no evidence of fracture or intracranial abnormalities. Dr. Talbot prescribed Fiorinal and Antivert. He recommended that Claimant remain off work until he re-evaluated him. Dr. Talbot scheduled a magnetic resonance scan to exclude a contusion and an electroencephalogram to exclude seizure discharged.

Dr. Talbot re-evaluated the Claimant on May 5, 1998. (CX 8; EX 13). He noted that Claimant had daily headaches maximum over the site of trauma and spreading left hemicranially that dissipated within twenty to thirty minutes with Fiorinal. He also noted daily dizzy spells with some days having more than one spell. Dr. Talbot stated the magnetic resonance scan of the brain showed no evidence of any contusion or any other post-traumatic abnormality. He stated the electroencephalogram was normal and revealed no evidence of seizure activity. Dr. Talbot stated that it was possible for Claimant to have partial seizures even with his non-confirmatory electroencephalogram and MRI scan. He recommended that Claimant discontinue the use of Antivert and prescribed Tegretol. He further recommended that Claimant not return to work until his spells were under control and his headaches improved.

Dr. Talbott submitted a third report dated June 16, 1998. (EX 4). He noted complaints of headaches, spells during the day involving the development of a vague distant expression and stiffening, spells at night involving shaking all over, and difficulty organizing thoughts. Dr. Talbott stated Claimant's most disabling condition was the spells that have only been partially responsive to Tegretol. He stated that based on the passing out spells, he had difficulty clearing Claimant to operate a motor vehicle which was necessary for him to return to even modified employment. He instructed continued use of Tegretol and prescribed Neurontin. He recommended evaluation by Dr. Valeriano.

5. Allegheny Open MRI Report

A brain MRI was performed on April 20, 1998. (CX 10; EX 4, 13, 14). The 3rd, 4th and lateral ventricles were normal in size and location. No intracranial abnormalities were seen. There was no evidence of a Chiari malformation. The impression was normal MRI of the brain.

6. Medical Reports of James Valeriano, M.D.

Dr. James Valeriano, who is Board-certified in psychiatry and neurology and clinical neurophysiology, submitted a report dated July 23, 1998, upon examining Claimant. (CX 12, 26; EX 6, 13). Dr. Valeriano stated that Claimant had a relatively small closed head injury to cause intractable epilepsy, but that it was not impossible for this to cause seizures. He recommended video EEG monitoring to better delineate the spells.

Dr. Valeriano conducted the video monitoring in September 21-24, 1998, at Allegheny General Hospital and submitted a report dated October 19, 1998. (CX 12; EX 6, 13, 14). An event that began with Claimant coughing followed by a to and fro head movement and by asymmetric rhythmic jerking at times in the left arm and at other times in the right arm was recorded. There was also abduction/adduction movements of the lower extremities in a non-rhythmic fashion. The EEG showed artifact, but immediately upon stopping the movement there were normal background rhythms. He opined that this represented a psychogenic seizure and did not represent true epilepsy. Dr. Valeriano could not say with certainty that Claimant did not have seizures, but stated part of the problem was psychogenic seizures. He recommended Claimant have a psychiatric referral and continue the anticonvulsant medications. He further recommended that Claimant not return to work.

In a letter dated November 25, 1998, Dr. Valeriano stated that Claimant's spells are related to his previous head injury. (CX 12).

In a report dated April 19, 1999, Dr. Valeriano reiterated that the event revealed during the video monitoring represented a psychogenic seizure and not true epilepsy. (EX 6). He opined that Claimant did not have epilepsy resulting from his head injury. Dr. Valeriano stated that neuropsychological testing did not reveal any significant CNS dysfunction from the head injury. Dr. Valeriana further stated that the psychogenic events began after the head injury, but whether

the injury caused the events was better related by a psychiatrist.

Dr. Valeriano submitted another report dated July 12, 1999. (CX 13). Dr. Valeriano stated that Claimant has done well with psychiatric counseling but that he continued to have occasional spells, particularly when upset. He further stated that Claimant has a sequelae of traumatic brain injury, especially a problem with anxiety, headache, loss of memory and probably some degree of depression. Dr. Valeriano opined that the symptoms are typical of traumatic brain injury. He further opined the proximate cause of Claimant's condition was the head injury sustained at work.

7. Allegheny General Hospital Medical Records

Claimant was admitted to Allegheny General Hospital for video EEG monitoring on September 21,1998. (CX 14; EX 6, 14). The principal diagnosis was OTH Convulsions. The secondary diagnoses were listed as tobacco use disorder, alc dep nec/nos-remiss, and comb drug dep nec-remiss. During a consult, Dr. Snyder noted that there was no evidence of overt malingering on exam. Dr. Patton V. Nickell conducted a psychiatry consultation during Claimant's admission. His impressions were no obvious psychiatric illness, seizures may represent conversion, but this diagnosis needs to be made only if his video monitored EEG is unremarkable, and drug and alcohol dependence, in remission by history.

8. Ravindra Mehta, M.D. Treatment Records

Dr. Ravindra Mehta's treatment records from March 16 through July 27, 1999, are in the record. (CX 15; EX 12). They document Claimant's therapy sessions. Dr. Mehta conducted a psychiatric evaluation on March 16, 1999. Dr. Mehta noted panic attacks beginning two weeks after the accident, fear of getting in a car, irritability, moodiness, forgetfulness, depression because inability to work, loss of memory, and difficulty sleeping. The provisional diagnoses were listed as: Axis I - mood disorder due to post concussive syndrome with major depressive like symptoms; Axis II - deferred; Axis III - post concussive syndrome, post traumatic seizures, status post head injury; Axis IV - social stressor; and Axis V - current GAF 55. On April 5, 1999, Dr. Mehta suggested relaxation therapy. On May 4, 1999, Dr. Mehta noted that Claimant was seeing a counselor and attending group therapy.

9. Chestnut Ridge Counseling Services, Inc. Treatment Records

Claimant's treatment records from Chestnut Ridge Counseling Services, Inc. are in the record. (CX 16; EX 8). The intake form dated November 4, 1998, for recorded Claimant's past psychiatric treatment history, current symptoms, drug and alcohol histories, and mental status exam. Psychiatric evaluation, medication and therapy was recommended. The progress record documents Claimant's cognitive behavior and reality therapy and his therapy for panic attacks.

10. Medical Report of Ravi Kant, M.D., B.C.F.M.

Dr. Ravi Kant, who is Board-certified in psychiatry, neurology and forensic medicine, submitted a medical report dated February 1, 1999, upon conducting a neuropsychiatric evaluation on January 25, 1999, and performing a record review. (CX 20, 27; EX 11). Dr. Kant diagnosed post concussion syndrome (with depression, irritability, cognitive defects, and mood swings), post traumatic seizures, R/O narcolepsy, status post head injury, and past history of alcohol abuse, currently in remission. Dr. Kant stated that the seizures were consistent with partial seizures. He further stated that it was not unusual for these seizures to show no EEG activity and the absence of activity should not be used to rule out seizure disorder. Dr. Kant indicated that Claimant suffered at least a moderate head injury that injured the olfactory nerve as evidenced by the loss of sense of taste and smell. He stated that it is not easy to differentiate between narcolepsy and partial seizures but the duration of the episodes where Claimant passes out or goes to sleep goes against the diagnosis of narcolepsy. Dr. Kant stated that without further evaluation and treatment it would be inappropriate to diagnose pseudoseizures.

Dr. Kant submitted a second report dated September 13, 1999, upon reviewing additional medical records. (CX 31). Dr. Kant stated that the records indicate no history of seizures, pseudoseizures, any head drops, headaches, dizzy spells, or any other symptoms of post concussion syndrome. Dr. Kant stated that this indicates that all of the symptoms have occurred since the accident and that Claimant was free of those symptoms during his treatment at Greenbriar. Dr. Kant stated that the records clearly established Claimant's level of functioning and how the Claimant has changed since the accident. He reiterated his conclusion in his first report and stated that Claimant's current symptoms, including partial seizure disorder, are secondary to the head injury.

11. Medical Report of Emira Zubchevich, M.D.[1]

Dr. Emira Zubchevich submitted a report dated September 21, 1999, upon conducting a psychiatric evaluation of Claimant. (CX 21). Dr. Zubchevich noted seizures, severe headaches, blackouts, sleeplessness, loss of memory, and history of alcohol and drug abuse. The diagnoses were listed as: Axis I - mixed disturbance of emotions and conduct, alcohol dependence in remission, cocaine dependence in remission; Axis II - unknown; Axis III - status after head trauma, repaired laceration above the left eyebrow and post concussion syndrome as evidenced by seizures suspected to be of psychogenic origin yet also having organic characteristics, severe headaches and emotional lability, status after rotator cuff injury (as reported by Greenbriar), hiatal hernia; Axis IV - father alcoholic, head injury at work, stressors-moderate; and Axis V - adaptive behavior is poor, the patient is incapable to adapt in social or occupational environments, GAF-40. Dr. Zubchevich stated that Claimant's prognosis was dubious. Dr. Zubchevich

[1]Dr. Zubchevich's report is labeled as consisting of eleven pages. Eleven pages were attached to the exhibit, but pages 3-5 of Dr. Zubchevich's actual report were not contained in those pages.

concluded that the memory impairment and concentration impairment resulted from head trauma sustained on April 7, 1998 and were severe enough to interfere with the performance of any task required by any type of gainful employment.

12. Greenbriar Treatment Center Treatment Records

Claimant was treated at Greenbriar Treatment Center for alcohol and drug abuse. (CX 23; EX 3). Claimant was diagnosed with alcohol and cocaine dependence. The integrated treatment assessments noted a head injury in 1990 approximately and a history of blackouts with excessive drinking. In a letter dated July 29, 1999, Dr. Oscar Urrea confirmed that Claimant was admitted to Greenbriar's Inpatient Treatment Program on October 23, 1997. (CX 22). Dr. Urrea confirmed that Claimant was discharged on November 5, 1997, after successful completion of the treatment program. He stated that Claimant did not suffer seizures during his inpatient stay.

13. Fayette Drug and Alcohol Commission Records

Claimant was treated at Fayette Drug and Alcohol Commission, Inc. (CX 24; EX 15). Dr. Zubchevich conducted a psychiatric evaluation on May 12, 1988. The diagnostic impression was alcoholism continuous, rule out bi-polar disorder and passive aggressive personality. Counseling and AA were recommended. Dr. Zubchevich, on the diagnostic consultation dated April 6, 1994, listed the diagnoses as: Axis I - cocaine and alcohol dependence; Axis II - anti-social personality; Axis III - healthy male; Axis IV - father alcoholic; and Axis V - adaptive behavior poor, patient incapable to adapt in social or occupational environment. The medical history taken on September 30, 1997, noted no history of troublesome headaches, seizures or sleeplessness.

14. Health First Medical Center Medical Records

Claimant was treated at Health First Medical Center by Dr. Fred Edge from July 25 through December 23, 1997. (EX 2). Claimant was seen at Health First for right shoulder and neck pain resulting from a truck rollover motor vehicle accident on July 12, 1997. Dr. Edge noted complaints of persistent headaches. Dr. Edge diagnosed severe cervico thoracic strain/sprain, brachial plexus neuritis and right shoulder strain/sprain.

15. Sahai Surgical Medical Records

Claimant was seen on July 9, 1998, at Sahai Surgical for possible seizure disorder. (EX 7).

16. Medical Reports and Testimony of Lawson Bernstein, M.D., P.C.

Dr. Lawson F. Bernstein submitted a report dated December 17, 1998. (EX 10, 14). In preparation of his report, Dr. Bernstein conducted a neuropsychiatric evaluation and record

review. He noted symptoms of blackouts, seizures, somnolence, narcoleptic symptoms with fear, chronic decrement in attention, concentration and short term memory, and increased irritability previously uncharacteristic for Claimant. Dr. Bernstein opined that Claimant has pseudoseizures but bona fide seizure disorder had not been disproved and recommended further testing. He stated that it was impossible to determine that Claimant did not have underlying seizure disorder because the testing was performed while taking anti-convulsants. Dr. Bernstein stated that Claimant's MMPI is consistent with symptom amplification/malingering and that Claimant had no active psychiatric disease beyond alcohol abuse in remission and anti social personality disorder. He stated that the malingering diagnosis was a suspicion as opposed to a firm clinical conclusion. He noted that there was no evidence on MMPI of major psychopathology beyond mild subclinical symptoms of anxiety and depression. Dr. Bernstein opined that Claimant was capable of gainful employment.

Dr. Bernstein submitted a second report dated September 9, 1999, upon reviewing additional records. (EX 17). Dr. Bernstein stated that the records revealed a past history of closed head injury, history of alcohol abuse and an adult history of significant cocaine abuse, history of psychiatric disease prior to the work-related injury, history of substance abuse and psychiatric disease in first-degree relatives, and an extensive history of legal problems. Based on the record review, Dr. Bernstein opined that Claimant suffered from a significant psychiatric disorder in the form of generalized anxiety disorder and/or panic disorder prior to the head injury. He stated that the records revealed a significant amount of pre-existing psychiatric dysfunction, which would lend credence of anti-social personality disorder, and provide an alternative explanation for the presence of pseudoseizures, including symptom amplification/malingering for secondary gain.

Dr. Bernstein was deposed on October 11, 1999. (EX 28). Dr. Bernstein testified that he is a neuropsychiatrist and is Board-certified in psychiatry, neurology and forensic medicine. Dr. Bernstein testified that the blackouts are consistent with binge drinking and can cause brain damage in the frontal and temporal lobes even in the absence of continual drinking. He stated that significant alcohol and substance abuse is highly associated with an adult history of psychiatric disease, particularly anxiety and depressive disorders. He further stated that long term alcohol abuse can lead to short and long term memory loss, loss of concentration and anxiety disorder. He stated that a traumatic brain injury can also cause loss of short-term memory, anxiety, depression, and headaches. Dr. Bernstein stated that cocaine abuse can enhance or cause anxiety symptoms and impair cognition and attention.

Dr. Bernstein stated that there was no evidence Claimant's seizures where neurologic. He opined that Claimant does not have a bone fide neurologically-based seizure disorder as confirmed by the video EEG and that Claimant is faking the seizures. He explained that a lot of patients who abuse drugs and alcohol are self-medicating underlying psychiatric problems and that once the abuse stops the problems surface in a variety of forms, including pseudoseizures. He stated that Claimant was at risk for a variety of psychiatric problems in the first year or two after abstinence from drugs and alcohol. Dr. Bernstein stated that his follow-up review of the records convinced

him that Claimant was malingering because Claimant failed to reveal his drug and alcohol abuse, criminal, medical, psychiatric, and family histories. He opined that the psychogenic seizures were not brought on by the work-related injury. Dr. Bernstein acknowledged that the Allegheny General Hospital records noted the following: no evidence of overt malingering; two clinical seizures during EEG testing; drug testing on September 23, 1998, was negative for cocaine use; and Claimant was open and forthright with the interview. He also acknowledged that the Greenbriar treatment records did not note a history of seizures and that Dr. Urrea stated there was no evidence of seizures while at Greenbriar.

Dr. Bernstein stated that the neurological events that contributed to Claimant's condition include the blackouts due to drug and alcohol abuse, at least one documented head injury, feelings of pain and episodes of falling off of a ladder, and the general propensity to bang the head while intoxicated. He stated that repeat or multiple neurologic events play a role in the severity of the symptoms. Dr. Bernstein opined that Claimant can work without restriction and is capable of driving and climbing heights. He further opined that Claimant has recovered from the injury at issue. Dr. Bernstein stated that being struck in the head by hundreds or tens of hundreds of pounds pales in comparison to a lifelong history of alcohol abuse, cocaine abuse, repetitive closed-head injury, psychiatric disease, and genetic loading for psychiatric disease.

17. Highlands Hospital Medical Records

Claimant was admitted from January 31 through February 6, 1996, at Highlands Hospital for an involuntary commitment for threatening to kill himself and his wife while under the influence of alcohol. (EX 29). The final diagnoses were chronic, moderate major depression and alcohol abuse and dependency. Claimant was detoxed off of alcohol and started on anti-depressants. He was transferred to an outpatient facility for further counseling. The records noted a long history of alcohol abuse and dependency, history of anxiety, blackouts and memory loss due to alcohol and drug abuse, and father's mental health problems.

18. Unpaid Medical Expenses

Claimant's unpaid medical expenses for Allegheny Neurological Associates, Dr. Mehta and Chestnut Ridge Counseling Services, Inc. are in the record. (CX 17, 18, 19).

C. Surveillance Evidence

An investigator employed at InPhoto Surveillance performed surveillance on Claimant from May 26 through May 28, 1998. (EX 18). InPhoto obtained approximately three minutes of videotape of Claimant sitting, slouching and riding in a vehicle. Claimant did not drive during the surveillance. InPhoto stated in their report that Claimant appeared to be physically handicapped and disabled.

An investigation and surveillance of Claimant was also conducted on September 18, 1998,

by Independent Research Group, Inc. (EX 18). The investigators documented Claimant's criminal history, civil suits and judgments, and his activities on September 18th. Independent Research Group obtained video tape activity of Claimant entering a Lowe's store with his father and purchasing a faucet and pipes.

IV. CONCLUSIONS OF LAW

A. Credibility Evaluations

It is well established that, in arriving at his or her decision, an Administrative Law Judge is entitled to evaluate the credibility of all witnesses, to draw his or her own inferences and conclusions from the evidence and is not bound to accept the opinion or theory of any particular medical examiner. *Quinones v. H.B. Zachery, Inc.*, 1998 WL 85580 (Ben. Rev. Bd. Feb. 10, 1998); *Avondale Shipyards, Inc. v. Kennel*, 914 F.2d 88, 91 (5th Cir. 1988); *Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce*, 661 F.2d 898, 900 (5th Cir. 1981); *Banks v. Chicago Grain Trimmers Association, Inc.*, 309 U.S. 459 (1968); *Scott v. Tug Mate, Inc.*, 22 BRBS 164, 165, 167, (1989); *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989). Accordingly, the Administrative Law Judge's credibility determinations will not be disturbed unless they are inherently incredible or patently unreasonable. *Quinones v. H.B. Zachery, Inc.*, 1998 WL 85580 (Ben. Rev. Bd. Feb. 10, 1998); *Cordero v. Triple A Machine Shop*, 580 F.2d 1331, 8 BRBS 744 (9th Cir. 1978), *cert. denied*, 440 U.S. 911 (1979).

Employer argues that Claimant's testimony is unreliable and should be rejected. Employer argues Claimant is an unreliable witness because of his history of alcohol and drug abuse, anti-social behavior and criminal history. As noted above, the administrative law judge has the discretion to determine the credibility of a witness. Furthermore, the administrative law judge may accept a claimant's testimony as credible, despite inconsistencies, if the record provides substantial evidence of claimant's injury. *Kubin v. Pro-Football, Inc.*, 29 BRBS 117, 120 (1995); *See Plaquemines Equipment & Machine Co. v. Neuman*, 460 F.2d 1241, 1243 (5th Cir. 1972).

There is no question that Claimant has a history of alcohol and drug abuse and criminal activity. Claimant admitted he is a recovering alcoholic and addict and that he entered Greenbriar to avoid going to jail. (Tr. 132, 147). He also admitted that he was in rehabilitation three times prior to Greenbriar and was only able to stay clean for four to five months. (Tr. 175). Despite this history, Claimant has been clean from drugs and alcohol for two years since treatment at Greenbriar. (Tr. 181-182; CX 14, 32). I find Claimant's testimony straight-forward and credible throughout the hearing.

Employer argues that the testimony of Mrs. Mitchell and Mr. Wayne Mitchell should be discounted based on an "obvious bias" toward Claimant. At the hearing, I had an opportunity to evaluate the credibility of these witnesses both on direct and cross examination. When considering all of the facts and the demeanor of the witnesses at trial, I find that both witnesses are credible.

B. Nature and Extent of Disability

In this case, the parties have stipulated that a work-related injury occurred on April 7, 1998, within the course and scope of the Claimant's employment with Centofanti Marine Services, Inc. (ALJX 1, Stipulation 1). Thus, the issue to be addressed is the nature and extent of Claimant's disability.

Section 2(10) of the LHWCA defines "disability" as the incapacity because of injury to earn the wages which the employee was receiving at the time of injury in the same or any other employment. 33 U.S.C. § 902(10). The question of extent of disability is an economic as well as a medical concept. *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Eastern S.S. Lines v. Monahan*, 110 F.2d 840 (1st Cir. 1940); *Rinaldi v. General Dynamics Corporation*, 25 BRBS 128, 131 (1991). In order for a claimant to receive disability benefits, he must have an economic loss coupled with a physical or psychological impairment. *Sproull v. Stevedoring Services of America*, 25 BRBS 100, 110 (1991); *Quick v. Martin*, 397 F.2d 644 (D.C. Cir. 1968); *Owens v. Traynor*, 274 F.Supp 770 (D.Md. 1967), *aff'd*, 396 F.2d 783 (4th Cir. 1968), *cert. denied*, 393 U.S. 962 (1968). Thus, the extent of disability cannot be measured by physical or medical condition alone. *Nardella v. Campbell Machine, Inc*., 525 F.2d 46 (9th Cir. 1975). Consideration must be given to claimant's age, education, industrial history, and the availability of work he can perform after the injury. *American Mutual Insurance Company of Boston v. Jones*, 426 F.2d 1263 (D.C. Cir. 1970). Disability is generally addressed in terms of its nature (permanent or temporary) and extent (total or partial).

The claimant bears the initial burden of establishing the nature and extent of any disability sustained as a result of a work-related injury without the benefit of the Section 20 presumption. *Lombardi v. Universal Maritime Service*, 32 BRBS 83 (1998); *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989); *Carroll v. Hanover Bridge Marina*, 17 BRBS 176 (1985); *Hunigman v. Sun Shipbuilding & Dry Dock Co.*, 8 BRBS 141 (1978). However, once the claimant has established that he is unable to return to his former employment because of a work-related injury or occupational disease, the burden shifts to the employer to demonstrate the availability of suitable alternative employment or realistic job opportunities which claimant is capable of performing and which he could secure if he diligently tried. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031 (5th Cir. 1981); *Air America v. Director*, 597 F.2d 773 (1st Cir. 1979); *American Stevedores, Inc. v. Salzano*, 538 F.2d 933 (2nd Cir. 1976); *Preziosi v. Controlled Industries*, 22 BRBS 468, 471 (1989); *Elliott v. C & P Telephone Co.*, 16 BRBS 89 (1984).

A claimant has the burden of proving a prima facie case of total disability by showing he cannot return to his regular employment due to a work-related injury. *Harrison v. Todd Pacific Shipyards Corp*., 21 BRBS 339 (1988)*; Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56, 59 (1980). At the initial stage, a claimant need not establish he cannot return to any employment, only that he cannot return to his former employment. *Elliott v. C & P Telephone Co.*, 16 BRBS 89 (1984); *Harrison v. Todd Pacific Shipyards Corp*., 21 BRBS 339 (1988)(due

to permanent restrictions against heavy lifting and excessive bending, employee could not resume usual job as sandblaster.)

The judge must compare the claimant's medical restrictions with the specific requirements of his usual employment. *Curit v. Bath Iron Works Corp*., 22 BRBS 100 (*1988); Mills v. Marine Repair Serv., 21 BRBS 115 (1988); Carroll v. Hanover Bridge Marine*, 17 BRBS 176 (1985); *Bell v. Volpe/Head Construction Co.*, 11 BRBS 377 (1979). A claimant's credible complaints of pain alone may be enough to meet his burden. *Anderson v. Todd Shipyards Corp*., 22 BRBS 20 (1989); *Richardson v. Safeway Stores*, 14 BRBS 855 (1982); *Miranda v. Excavation Construction*, 13 BRBS 882, 884 (1981). However, a judge may find an employee able to do his ususal work despite complaints of pain, numbness, and weakness, when a physician finds no functional impairment. *Peterson v. Washington Metro Area Transit Authority*, 13 BRBS 891 (1981).

The traditional method for determining whether an injury is permanent or total is the date of maximum medical improvement. *Turney v. Bethlehem Steel Corp*., 17 BRBS 232, 235, ftn 5 (1985); *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56, 59 (1980); *Stevens v. Lockheed Shipbuilding Company*, 22 BRBS 155, 157 (1989). Any disability before reaching maximum medical improvement is temporary in nature. *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56, 60 (1980).

The date of maximum medical improvement is defined as the date on which the employee has received the maximum benefits of medical treatment such that his condition will not improve. The date on which a claimant's condition has become permanent is primarily a medical determination. *Manson v. Bender Welding & Mach. Co.*, 16 BRBS 307, 309 (1984). However, if the medical evidence indicated that the treating physician anticipates further improvement, unless the improvement is remote or hypothetical, it is not unreasonable for a judge to find that maximum medical improvement has been reached. *Dixon v. John J. McCullen & Assoc*., 19 BRBS 243, 245 (1986); *See Mills v. Marine Repair Serv*., 21 BRBS 115, 117 (1988).

A judge must make a specific factual finding regarding maximum medical improvement, and cannot merely use the date when temporary total disability is cut off by statute. *Thompson v. Quinton Eng'rs*, 14 BRBS 395, 401 (1981). If a physician does not specify the date of maximum medical improvement, however, a judge may use the date the physician rated the extent of the injured worker's permanent impairment. *See Jones v. Genco, Inc*., 21 BRBS 12, 15 (1988). The date of permanency may not be based on the mere speculation of a physician. *Steig v. Lockheed Shipbuilding & Construction Co.*, 3 BRBS 439, 441 (1976). In the absence of any other relevant evidence, the judge may use the date the claim was filed. *White v. General Dynamics Corp*., 8 BRBS 706, 708 (1978).

I will address the nature and extent of disability and maximum medical improvement concurrently.

There are five physician reports in the record, with only one physician, Dr. Bernstein testifying. Initially, I accord less weight to the opinions of Drs. Valeriano and Zubchevich. Dr. Valeriano did not reference or mention in any of his reports Claimant's history of drug and alcohol abuse. I assume because he failed to mention the abuse history that he had no knowledge of them. Dr. Zubchevich, on the other hand, had knowledge of Claimant's drug and alcohol abuse, but three pages of her report were missing and not entered as part of the record. Thus, I accord less weight to her opinion because her report was incomplete.

Dr. Bernstein was the only expert to testify. I find Dr. Bernstein's opinion to be inconsistent and equivocal for the following reasons. First, Dr. Bernstein testified that Claimant was "faking" the seizures. Later at his deposition, he testified that because of Claimant's history of alcohol and drug abuse, it was logical to have a variety of psychiatric complaints and symptoms in the first year or two after abstinence, including pseudoseizures. (Tr. 68-69). He then admitted that Claimant did not experience seizures while undergoing detoxification at Greenbriar. (Tr. 88). Dr. Bernstein appears to be testifying that Claimant has no symptoms but any symptoms that he does have are a result of his drug and alcohol abuse. I find his opinion to be disingenuous. Secondly, Dr. Bernstein testified that Claimant's blackouts are consistent with binge drinking. I find that Dr. Bernstein failed to take into account that there is no evidence in the record that Claimant is currently consuming alcohol and Claimant's testimony that he has been clean from drugs and alcohol for two years. (Tr. 181-182). Furthermore, I find that Dr. Bernstein failed to take into account Claimant's testimony that the blackouts he has been experiencing since the accident are not the same type of blackouts he had when he was drinking. (Tr. 171). For these reasons, I accord less weight to Dr. Bernstein's opinion.

Dr. Kant was aware of both Claimant's drug and alcohol abuse history and prior head injury history. Dr. Kant reviewed numerous medical records in addition to evaluating Claimant. He stated that there was no obvious evidence of any malingering or embellishment of symptoms during the evaluation. Dr. Kant explained that Claimant's episodes were consistent with partial seizures which are difficult to detect on EEG and that it was not unusual for associated EEG activity not to be recorded. Indeed, Dr. Talbot also explained that it was possible for Claimant to have partial seizures even with his non-confirmatory electroencephalogram and MRI scan. Dr. Kant agreed with Dr. Bernstein's initial opinion that a repeat video EEG should be performed with Claimant tapered off of anticonvulsants, but disagreed with Dr. Bernstein's diagnosis of malingering solely based on MMPI especially when the K Scale score is lower than expected. Dr. Kant stated that the records indicated no history of Claimant's current symptoms, thus indicating that the symptoms have occurred since the accident. Dr. Kant stated that the records clearly established Claimant's level of functioning and how the Claimant has changed since the accident. He stated that Claimant's current symptoms, including partial seizure disorder, are secondary to the head injury. I find Dr. Kant's opinion to be well reasoned and accord it greater weight.

Accordingly, for the reasons set forth above, I credit the well reasoned opinion of Dr. Kant, as supported by Dr. Talbot, over the opinions of Drs. Valeriano, Zubchevich, and Bernstein.

Based on the evidence of record and the credible testimony at hearing, I find that Claimant continues to be totally disabled. The medical evidence documents the chronic nature of Claimant's symptoms as occurring after the work-related injury. For example, on July 2, 1998, Claimant was taken to Brownsville General Hospital's emergency room by ambulance upon having a seizure. The Greenbriar treatment records noted no history of seizures and a medical history taken in September of 1997 at Fayette Drug and Alcohol Commission also indicated no history of troublesome headaches or seizures. Dr. Kant upon reviewing the medical records stated that they did not indicate a history of seizures, head drops or dizzy spells.[2] Claimant testified that he did not experience seizures, blackouts, headaches, and memory loss prior to the work-related injury. (Tr. 146). He also testified that he did not experience memory loss while using drugs or alcohol. (Tr. 180). Claimant's testimony was corroborated by the testimony of his wife and his father. (Tr. 41, 94, 5760, 64, 106-107, 113, 109121-122). Based on the medical evidence and Claimant's testimony, I find Claimant has shown by a preponderance of the evidence that he can no longer perform his former job because of his work-related injury.[3]

None of the physicians addressed whether Claimant has reached maximum medical improvement. Therefore, due to the lack of evidence regarding maximum medical improvement, I find Claimant has not proven a permanent disability. Thus, I further find Claimant's disability is temporary.[4]

In conclusion, on the basis of the record provided, I find that the Claimant has established that he cannot work as a welder due to injuries suffered on April 7, 1998 and is entitled to temporary total disability benefits, commencing as of April 8, 1998.

C. Medical Expenses and Benefits

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[2]Claimant reported headaches to Dr. Edge who treated his injuries in connection with the truck rollover accident. (EX 2). He testified that the headaches were different from those he experiences post-injury. (Tr. 179).

[3]When a claimant proves he cannot return to his usual work, the burden shifts to the employer to show suitable alternative employment or realistic job opportunities in the relevant geographic market which claimant is capable. *Clophus v. Amoco Prod. Co.*, 21 BRBS 261 (1988). In the case at bar, the employer did not submit any evidence as to the availability of suitable alternative employment. *See Pilkington v. Sun Shipbuilding and Dry Dock Company*, 9 BRBS 473 (1978), *aff'd on reconsideration after remand*, 14 BRBS 119 (1981). *See also Bumble Bee Seafoods v. Director, OWCP*, 629 F.2d 1327 (9th Cir. 1980). I therefore find Claimant has a total disability.

[4]Claimant received temporary total disability payments in the amount of $208.94 per week for thirty (30) weeks, commencing on April 8, 1998 and extending through November 3, 1998, for a total of $6,268.20. (ALJX 1, Stipulation 6).

Section 7(a) of the LHWCA provides that "[t]he employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a); *See also* 20 C.F.R. § 702.401. In order for a claimant to receive medical expenses, his injury must be work-related. *Romeike v. Kaiser Shipyards*, 22 BRBS 57, 60 (1989). Additionally, the expenses must be reasonable and necessary. *Pernell v. Capitol Hill Masonry*, 11 BRBS 532, 539 (1979).

The parties have stipulated that a work-related injury occurred on April 7, 1998, accordingly Claimant is entitled to compensable medical treatment associated with that injury. In light of my findings above that Claimant is temporarily and totally disabled due to his injuries suffered on April 7, 1998, I find that his treatment for his injuries are compensable under the Act. Employer is ordered to pay any outstanding medical bills and to provide future reasonable, necessary and appropriate medical care related to Claimant's work-related injury.

D. Average Weekly Wage

The parties have stipulated that Claimant's average weekly wage ("AWW") is $247.10. (ALJX 1, Stipulation 8). The parties further stipulated that Claimant's compensation rate (AWW x 2/3) is $208.94. (ALJX 1, Stipulation 9).

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I issue the following compensation order.

It is therefore ORDERED that:

1. Employer shall pay to Claimant compensation for his temporary total disability benefits from April 8, 1998, based on an average weekly wage of $208.94.

2. Employer shall receive credit for all amounts of compensation paid previously paid to Claimant as a result of his April 7, 1998 injury;

3. Pursuant to § 7 of the Act, Employer shall pay or reimburse Claimant for all reasonable, appropriate and necessary medical expenses as Claimant's work-related injury referenced herein may require, with interest in accordance with Section 1961. *See* 33 U.S.C. § 907.

4. Claimant's counsel shall have twenty (20) days from receipt of this Order in which to file a fully supported attorney fee petition and simultaneously to serve a copy on opposing counsel. Thereafter Employer shall have twenty (20) days from receipt of the fee petition in which to file a response.

5. All computations of benefits and other calculations which may be provided for in this ORDER are subject to verification and adjustment by the District Director.

6. Claimant, at his own expense, shall be tested for alcohol and drug use on a monthly basis at Greenbriar Treatment Center, his family physician's office, or any other qualified drug testing center, continuing as long as Claimant is temporary and totally disabled. Said testing center shall forward certification of such testing to the District Director.

MICHAEL P. LESNIAK
Administrative Law Judge

MPL/lmk